



Form must be printed and submitted in hard copy: TYPE ONLY.

### Personal Information:

Name:      
[Last Name] [First Name] [Middle Initial] [Degrees]

DOB:   
[MM/DD/YYYY]

Mailing Address:   
[Street Address]

Tel 1:   
[Business phone, please include Country Code]

Tel 2:   
[Home phone, please include Country Code]

[City] [State/Province] [Zip/Postal Code] [Country]

Fax:   
[Please include Country Code]

E-mail:

### Academic Training:

	Institution	Degree	Year
Pre-Dental or Pre-Medical			
Dental or Medical			
Graduate			

### Post Graduate

List all short courses in last five years. Use additional page if necessary.

Course	Institution	Degree	Year

### Specialty Board Certification



### Teaching or Hospital Appointments:

Institution	Appointment	MM/DD/YYYY

### Research Experience (list project, grant source if applicable):

Research Project	Grant Source	MM/DD/YYYY

List papers, essays, clinics, or exhibits presented by you at dental or other professional meetings and the dates. Use separate sheet if necessary.


List memberships in professional and scientific organizations (ADA, etc.) and offices held.


Names of two Active Fellows of the Academy from whom the Secretary may obtain an endorsement.




**What is your purpose in wanting to join the Academy and in what capacity do you believe you can best serve the Academy?**

**If elected to membership in the American Academy of Maxillofacial Prosthetics, I agree to abide by the Constitution, By-Laws and other rulings of the Academy as well as such changes and amendments as may thereafter be properly adopted.**

[Signature]

[MM/DD/YYYY]

IMPORTANT: Affix a recent 2" X 3" photograph.

[Do not write in these spaces]

Date Application received:

[MM/DD/YYYY]

Approved/Rejected By:

Fellowship Committee:

Approved/Rejected by the Board of Directors:

**Complete Form and Mail to:**

Dr. Thomas Salinas  
200 First Street SW  
Rochester, MN 55905  
USA

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Fax: (507) 284-8082  
E-mail: salinas.thomas@mayo.edu